# King County Deputy Sheriff Regence Medical/Vision Plan

**Finalized April 9, 1999**
**Printed & Distributed August 1999**

# Directory

| If you have questions about … | Contact … |
|---|---|
| • Eligibility<br>• Completing the enrollment form<br>• King County Deputy Sheriff benefit program | Employee Benefits and Well-Being at (206) 684-1556<br>Monday – Wednesday between 8:30 a.m. and 4:30 p.m.<br>Thursday between 10:30 a.m. and 4:30 p.m.<br>Friday between 8:30 a.m. and 4:30 p.m.<br><br>King County employee intranet (through the King County computer system) at http://ohrm/metrokc.gov/benefits |
| • Details about plan benefits (such as covered expenses, limitations, exclusions)<br>• Participating providers<br>• Out-of-area coverage<br>• Specific medical conditions or treatment<br>• Filing claims | Regence BlueShield (formerly King County Medical Blue Shield) at (206) 464-3663 or (800) 544-4246<br>Monday – Friday between 7:30 a.m. and 5:00 p.m. |
| • General information about Regence BlueShield (King County-specific information on benefits is not available on the Regence web site)<br>• Participating provider list for all participants (including King County employees) | Regence web site at www.regence.com |
| • Preadmission approval | Regence at (206) 464-3748 or (800) 367-2766<br>Monday – Friday between 7:30 a.m. and 5:00 p.m. |

*The information in this booklet is available in accessible formats by calling Employee Benefits at (206) 684-1556 (voice) or (206) 296-8535 (TDD), or through Washington State Telecommunication Relay Service at (800) 833-6388 (TDD).*

## HOW TO USE THIS BOOKLET

This booklet describes the medical coverage available to you and your family members under the Regence Medical Plan if you are an eligible King County Deputy Sheriff employee. It summarizes the benefits, describes when coverage begins and explains how to use the plan. See your enrollment materials for details on enrollment procedures and deadlines, coverage options and related cost information.

Shaded areas throughout the booklet highlight key points for your convenience.

*This booklet uses a number of technical terms you will need to know to understand your benefits. For your reference, we've defined many terms in "Definitions" starting on page 52.*

Keep this booklet and refer to it whenever you have a question about your Regence medical coverage. If you still have questions, contact the plan at the phone number or web site listed in the Directory in the front of this booklet. You may also call Employee Benefits and Well-Being at (206) 684-1556.

Although this booklet includes certain key features and brief summaries of this medical coverage, it does not provide detailed descriptions. If you have questions about specific plan details, contact the plan or Employee Benefits and Well-Being.

We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this booklet and the insurance contracts or other legal documents, the legal documents will always govern.

King County intends to continue this plan indefinitely but reserves the right to amend or terminate it at any time, for any reason, according to the amendment procedures described in the legal documents.

This booklet does not create a contract of employment with King County.

## LEARN MORE ABOUT … ON PAGE …

*Visit the King County employee intranet (accessible only through the King County computer system) at http://ohrm/metrokc.gov/benefits*

*Visit the Regence web site at www.regence.com for general information about Regence. Note: For King County-specific benefit information (for example, covered expenses), consult this booklet.*

## LEARN MORE ABOUT (cont'd)… ON PAGE …

## HIGHLIGHTS

Medical coverage offers financial protection for you and your family members in the event of illness or injury.

Regence BlueShield Medical Plan was formerly known as King County Medical Blue Shield.

*A current list of participating providers is available from Regence. (Call Regence or visit their web site.)*

To receive benefits from the Regence Medical Plan:

- You make an appointment with a participating (or approved) provider (see definition on page 53).
- The plan pays 80% - 100% for most covered services.
- Your participating provider will file claims for you (see definition on page 53).

## WHO'S ELIGIBLE

### Employees

You are eligible for medical coverage if you are:

- A represented, commissioned employee in a regular, active, year-round position and scheduled to work at least 35 hours each week, or
- A represented, commissioned employee in a regular, active, year-round position and scheduled to work under 35 hours each week — if your position has at least 10 pay periods of uninterrupted service a year with 5 full-time work days or the equivalent of 35 hours a pay period

### Retiree

Retirees are not eligible for this plan.

## Family Members

*A child is your natural child, adopted child, legally placed foster child, stepchild, legally designated ward, child placed with you as legal guardian, child legally placed with you for adoption, or a child for whom you assume total or partial legal obligation for support in anticipation of adoption.*

The following family members are eligible for medical coverage:

- Your spouse or domestic partner named on the Affidavit of Marriage/Domestic Partnership on file with Employee Benefits and Well-Being.
- Unmarried children of you, your spouse or declared domestic partner who are:
  - Under age 23 and chiefly dependent on you, your spouse, your declared domestic partner or the non-covered legal parent for support and maintenance (generally, that means family members you claim on your federal tax return).
  - Incapacitated due to developmental or physical disability and chiefly dependent on you for support and maintenance. The child must have become incapacitated while covered by the plan and before age 23. You must submit proof of the child's disability for enrollment (and periodically thereafter).

*To continue an incapacitated child's coverage after age 23, contact Employee Benefits and Well-Being within 60 days of the child's 23rd birthday.*

  - Named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the plan. See page 42 for details.

# COST

*The county pays the full monthly cost of coverage for you and your eligible family members under this plan.*

When you receive medical care under the Regence Medical Plan, you pay:

- Any required copays at the time of service
- Coinsurance, if any (see definition on page 54)
- Annual deductible
- Amounts in excess of the allowed amount (see page 52 for definition)

- Expenses for services or supplies not covered by this plan.

## ENROLLING IN THE PLAN

*Your eligibility date is the first day of the calendar month after 3 months of continuous service.*

If you are a newly hired employee, you must submit a completed enrollment form to Employee Benefits and Well-Being within 30 days of your hire date. See your enrollment materials for details.

### Making Changes

Each year during open enrollment, you may change your elections.

*To add coverage during the plan year, notify Employee Benefits and Well-Being and submit a completed enrollment form within 60 days of the family status change. Otherwise, you must wait until the next open enrollment period.*

You may drop family members' coverage anytime during the year. You may add family members' coverage during the plan year if any of these changes in family status occurs:

- Birth or placement of a child with you for adoption
- Placement of a foster child
- Loss of your child's eligibility under another health plan
- Death of a family member
- Marriage or establishment of a domestic partnership
- Divorce or dissolution of a domestic partnership
- Significant change in your spouse's or domestic partner's coverage attributable to his or her employment.

*Enrollment forms are available from and must be submitted to Employee Benefits and Well-Being. You'll need to file a revised enrollment form within 60 days if there is any change in your family's eligibility.*

Any change you make must be consistent with the change in family status. Here are several examples:

- If you adopt a child, you may add coverage for that child (you may not add coverage for your other children at that time)
- If your child loses coverage under your spouse's coverage, you may add this child to the county's plan
- If you get married, you may enroll your new spouse and his or her eligible children.

## WHEN COVERAGE BEGINS

*If you join during open enrollment, coverage is in effect for the entire plan year (if you remain eligible). See your enrollment materials for details.*

If you enroll during the year as a newly hired employee, your Regence medical coverage begins on the first day of the calendar month after you complete 3 months of work. If your first day of employment is the first working day of the month for your position, that month applies to the waiting period. For example, if your first scheduled day of work is Saturday, April 3 (because Thursday and Friday will be your regular days off), your coverage begins July 1. If your first day of employment is April 15, your coverage begins August 1. To be covered during these first 3 months, you must self-pay.

If enrolled by the deadline (described in "Making Changes" starting on page 3), coverage for your:

*Coverage for your family members does not start until your coverage begins and you submit a completed enrollment form listing the family members you want to cover. If your dependents are not enrolled in this plan and have other coverage — and lose that other coverage — they may be able to enroll in this plan during the year. Contact Employee Benefits and Well-Being at (206) 684-1556 for more information.*

- Newborn or newly placed adopted child is retroactive to the date of birth or placement
- New spouse begins the first day of the calendar month after you're married
- Domestic partner begins the first day of the calendar month after the date you establish a domestic partnership as indicated on the Affidavit of Marriage/Domestic Partnership.

According to Washington State law, coverage is provided for newborns under the mother's coverage for the first 3 weeks of life. To continue the newborn's coverage after 3 weeks, the newborn must be eligible and enrolled by the deadline described in "Making Changes" on page 3.

## PREEXISTING CONDITIONS

There is no preexisting condition limit under this plan.

# HOW THE REGENCE MEDICAL PLAN WORKS

## Medical Plan Summary

The following table summarizes covered services and supplies under the Regence Medical Plan and identifies related coinsurance, copays, maximums and limitations. Please see "Covered Expenses" and "Expenses Not Covered" for more information on your medical benefits.

| | Regence Medical Plan | For More Information Refer To … |
|---|---|---|
| **Annual deductible** | $100/person<br>$300/family | Page 8 |
| **Annual out-of-pocket maximum** (excluding the deductible) | $375/person | Page 8 |
| **Lifetime maximum** | $1,000,000/person | Page 9 |
| **Covered Expenses** | **Plan Pays** | **For more information refer to …** |
| **Additional benefits for LEOFF I employees** | Not covered | Page 13 |
| **Alternative care** | Not covered | Page 13 |
| **Ambulance services** | 80% | Page 14 |
| **Chemical dependency treatment** (up to $5,000 in plan payments every 2 calendar years; lifetime benefit maximum of $10,000)❷ | 100% | Page 14 |
| **Chiropractic care** | 100% | Page 14 |
| **Diabetes care training** | 100% | Page 15 |
| **Durable medical equipment, prosthetics, orthopedic appliances** | 80% | Page 15 |
| **Emergency care** (in an emergency room) | 80% after $25 copay<br>(waived for accidental injury, for surgery or if directly admitted ) | Page 16 |
| **Family planning** | Covered at various levels;<br>call plan for details | Page 17 |
| **Growth Hormones** | 90% | Page 17 |
| **Home health care** (up to 130 visits/year) | 90% | Page 17 |
| **Hospice care** (The greater of 6 months or $10,000 lifetime maximum) | 90% | Page 19 |

Covered expenses applied to the deductible during the last 3 months of the plan year also will be applied to the next year's deductible.

❷ Any chemical dependency benefits provided during the previous 24 months under this or any other plan will be charged against the 2-year benefit limit.

## Medical Plan Summary (cont'd)

| Covered Expenses | Plan Pays | For More Information Refer To … |
|---|---|---|
| **Hospital care** ❹ — inpatient and outpatient (inpatient subject to preadmission approval) | 80% | Page 21 |
| **Infertility** | Physician services: 100%<br>Hospital services: 80% | Page 22 |
| **Injury to teeth** (deductible does not apply) | Up to $600/injury<br>Physician/Dentist/Denturist services: 100%<br>Hospital services: 80% | Page 23 |
| **Inpatient care alternatives** | Not covered | Page 23 |
| **Lab, x-rays and other diagnostic testing** | Physician services: 100%<br>Hospital services: 80% | Page 23 |
| **Manipulative therapy** | See chiropractic care | Page 14, 23 |
| **Maternity care** | Physician services: 100%<br>Hospital services: 80% | Page 24 |
| **Mental health care** | | Page 24 |
| – Inpatient | 100% up to 8 days/year | |
| – Outpatient | 50% up to 12 visits/year | |
| **Neurodevelopmental therapy** | 80% up to $2,000 annual benefit maximum | Page 25 |
| **Newborn care** (up to at least 3 weeks as mandated by state law) | Physician services: 100%<br>Hospital services: 80% | Page 26 |
| **Physician and other medical and surgical services** | | Pages 12, 26 |
| – Physician services in an office, home, hospital and skilled nursing facility | 100% | |
| – Surgery | Physician services: 100% | |
| – Lab and x-ray | 100% | |
| **PKU formula** | 100% | Page 26 |
| **Prescription drugs** | | Page 26 |
| – Generic | 100% | |
| – Brand-name | 80% | |
| **Preventive care** | 100% | Page 27 |
| **Radiation therapy, chemotherapy and respiratory therapy** | Radiation and chemotherapy: 100%<br>Respiratory therapy: See home health, hospice or hospital care. | Page 27 |
| **Reconstructive services** | 100% | Page 27 |

If the same hospitalization continues from 1 year into the next, a second deductible will not be required for any treatment before discharge. Additional coinsurance also will not be required for any treatment before discharge if you've met the out-of-pocket maximum for the year the hospitalization began.

❹ See page 11 for details on preadmission approval.

.

| Covered Expenses | Plan Pays | For More Information Refer To … |
|---|---|---|
| **Rehabilitative services❺** | | Page 28 |
| – Inpatient | 100% up to $50,000/condition | |
| – Outpatient | 80% up to $2,000/year | |
| **Skilled nursing facility** | 80% | Page 29 |
| **Smoking cessation** (lifetime benefit maximum of $500) | 75% | Page 29 |
| **Sterilization procedures** | 100% | Page 30 |
| **Supplemental accident benefits** (deductible does not apply) | 100%, up to $600/injury | Page 30 |
| **TMJ** | Not covered | Page 30 |
| **Transplants** — Certain services only (donor organ procurement costs up to $25,000; travel expenses up to $2,500/transplant) | Physician and travel expenses: 100%<br>Hospital services: 80% | Page 30 |
| **Urgent care** | Covered at various levels;<br>call Regence for details | Page 32 |
| **Vision care** (deductible does not apply) | 100% for 1 exam/calendar year | Page 32 |

❺ If you had an inpatient rehabilitative admission for the condition and did not exhaust your $50,000 inpatient benefit, you may apply for additional outpatient benefits beyond the $2,000 limit. Contact Regence for details.

## How the Plan Pays Benefits

The following chart shows how benefits are determined for most covered expenses.

| Plan Feature | Regence Medical Plan |
|---|---|
| You pay the annual deductible | $100/person; $300/family |
| After the deductible and copay (if any) the plan pays most covered services at this level until you reach your out-of-pocket maximum . . . | 80% - 100%<br>See "Medical Plan Summary" for amounts |
| Then the balance of most covered expenses for the year is paid at . . . | 100% |

## Annual Deductible

*If you and your family members are in the same accident, only 1 deductible will apply.*

Before you receive plan benefits, you must meet the annual deductible shown above.

If 3 or more family members together incur $300 in covered expenses for the Regence Medical Plan, you meet the family deductible. This means no further deductible will be required from any family member for the rest of that year.

## Annual Out-of-Pocket Maximum

The out-of-pocket maximum is the most you pay in coinsurance for covered expenses each year. This means once you've reached your out-of-pocket maximum, the plan pays 100% for most covered expenses for the rest of that year.

Your annual out-of-pocket maximum is $375 per person. The following don't apply to the out-of-pocket maximum:

- Annual deductible
- Emergency room copay
- Outpatient care for rehabilitative services
- Outpatient mental health care
- Neurodevelopmental therapy coinsurance

- Amounts in excess of the allowed amount
- Charges beyond benefit maximums
- Expenses not covered under the plan
- The 50% coinsurance you pay if:
  - You don't obtain a required second opinion (see page 10)
  - Inpatient admission is not medically necessary (see page 11) or
  - Certain surgeries are performed on an inpatient basis (see page 12).

## Lifetime Maximum

The total amount paid for all benefits from the Regence Medical Plan is limited to a lifetime maximum of $1,000,000 per person. Up to $20,000 of this maximum is restored automatically at the start of each year for benefits paid during the prior year. Some expenses are also subject to annual or lifetime benefit limits; see "Medical Plan Summary" starting on page 5.

## Accessing Care

*A current list of participating providers is available from Regence.*

To receive benefits from the Regence Medical Plan:

- You make an appointment with a participating (or approved) provider
- The plan pays 80% - 100% for most covered services
- Your participating provider will file claims for you (see page 40 for information on how to file a claim from a non-participating provider).

If your family member lives away from home and outside the service area, see page 37 for more information on plan benefits.

If you're traveling outside the service area and need medical attention, see page 37 for details.

## Mandatory Second Surgical Opinions (Applies to LEOFF II Employees Only)

*If you are a LEOFF I employee, the requirements under Mandatory Second Surgical Opinions don't apply to you.*

When performed at your convenience and not as an emergency, the following procedures require a second opinion:

- Bunionectomy (removal of a bunion)
- Cholecystectomy (removal of gall bladder)
- Coronary bypass (heart bypass surgery)
- Dilatation and curettage (dilatation of cervix and scraping of uterus)
- Excision (removal) of cataracts
- Hemorrhoidectomy (removal of hemorrhoids)
- Inguinal hernia repair (hernia in the groin)
- Hysterectomy (removal of uterus)
- Knee surgery
- Laminectomy or spinal fusion (removal or welding of parts of the spine)
- Mastectomy (partial or complete removal of the breast tissue)
- Prostatectomy (removal of the prostate)
- Rhino-septoplasty (nose surgery for functional improvement)
- Tonsillectomy and/or adenoidectomy (removal of tonsils/adenoids)

*Once you receive the second opinion, even if the providers do not agree, the decision to have the surgery will rest with you. Plan benefits will be provided as long as surgery is performed within 6 months of the second opinion.*

- Varicose vein stripping and ligation (removal and tying of varicose veins).

*Second opinions for certain surgeries may be waived by Regence based on information from your provider.*

The provider's services as well as related x-ray and lab charges will be paid in full for the second opinion and are not subject to the annual deductible. If you don't obtain the second opinion, benefits will be paid at 50% of the allowed amount. You will be responsible for the additional charges.

The second opinion must be obtained from a different provider than the one who will perform the surgery. Call Regence to be referred to a provider approved for second opinions.

A third opinion also will be covered if the first 2 opinions disagree.

## Obtaining Preadmission Approval for Inpatient Care (Applies to LEOFF II Employees Only)

*If you are a LEOFF I employee, the requirements under Preadmission Approval don't apply to you.*

If you are a LEOFF II employee, before an inpatient admission, have your provider submit a Preadmission Review Request form (available from Regence) at least 10 days before your admission date. If this is not possible, your provider may call (206) 464-3748 to obtain approval. Regence will evaluate the information from your provider to determine in advance whether inpatient care meets the plan's definition of medically necessary. All nonemergency medical and surgical services must be on an outpatient basis, unless Regence determines inpatient hospital or skilled nursing facility care meets the plan's definition of medically necessary. The approval will be valid for 6 months, but you'll need a new approval for each admission or readmission.

*Preadmission approval is not necessary for emergency services or maternity admissions.*

If you don't obtain preadmission approval, Regence will assess whether inpatient care meets the definition of medically necessary when you submit the claim. If inpatient care is determined to not meet the plan's definition, your benefits for inpatient hospital or skilled nursing facility care, including any related provider services, will be 50% of the allowed amount or the amount that would have applied in an appropriate alternative setting — whichever is greater. (See page 52 for a definition of

allowed amount). You'll be responsible for additional charges. Of course, Regence is only responsible for determining the benefits that are payable under this plan. It is up to you and your provider to determine the care that you believe is appropriate for your situation, regardless of whether the care is covered under this plan. Neither Regence nor the County provide medical advice.

## Preadmission Testing for Surgery

Outpatient preadmission testing for surgery is covered if performed at the hospital where you would be confined and if you're admitted within 48 hours after testing begins.

## Mandatory Outpatient Surgery (Applies to LEOFF II Employees Only)

*If you are a LEOFF I employee, the requirements under Mandatory Outpatient Surgery don't apply to you.*

Surgical procedures are covered under this plan. However, the following procedures must be obtained (if you are a LEOFF II employee) in an outpatient setting to receive full plan benefits:

- Arthroscopy (instrumental examination of a joint); arthroscopic surgery of the knee
- Biopsy and excision of readily accessible lesions that can be done with local or topical anesthesia (such as skin, oral cavity, vagina, rectosigmoid)
- Cataract extraction not complicated by serious medical conditions
- Diagnostic dilatation and curettage (not in conjunction with major surgery, pregnancy or hemorrhage)
- Endoscopic procedures that are uncomplicated, do not require a general anesthetic and are not in conjunction with major surgery (includes laryngoscopy, bronchoscopy, esophagoscopy, proctosigmoidoscopy and colonoscopy)
- Foot surgery confined to 1 foot and not complicated by serious medical conditions

*If these procedures are performed on an inpatient basis, payment will be 50% of the allowed amount, unless you have a documented medical condition which makes inpatient admission medically necessary. You will be responsible for the additional charges.*

- Procedures on the genitourinary system unless in conjunction with major surgery or complicating conditions
- Incision and drainage of uncomplicated abscesses and cysts including myringotomy (incision of the ear drum)
- Uncomplicated nasal surgery such as for polyps or deviated septum
- Surgical sterilization (vasectomy and laparoscopic tubal ligation) unless in conjunction with major procedures or complicating conditions
- Tonsillectomy and/or adenoidectomy under age 12.

### If You Live Outside the Service Area

*Call Regence for information on service areas.*

If you live outside the service area, benefits are paid as if you lived within the service area (see page 37 for more information).

## COVERED EXPENSES

*Regence Medical Plan covers illnesses and injuries on and off the job for LEOFF I employees if the claim has been denied by Workers' Compensation. For all other employees, Workers' Compensation generally covers on-the-job injuries.*

The following section describes expenses covered by the Regence Medical Plan. For information on the level of benefits you receive, (for example, related coinsurance, copays, maximums and limitations), refer to "Medical Plan Summary" starting on page 5. Also see "Expenses Not Covered" starting on page 32.

### Additional Benefits for LEOFF I Employees

*LEOFF I refers to firefighters and law enforcement officers who are members of LEOFF Plan I.*

Previous versions of this plan provided additional benefits for LEOFF I employees. These benefits are no longer available under this plan.

## Alternative Care

*Only medically necessary services and supplies are covered by the Regence Medical Plan. See page 56 for a definition of medically necessary.*

With the exception of chiropractic care on page 14, alternative care is generally not covered under the Regence Plan.

## Ambulance Services

Licensed ambulance services are covered if other travel would endanger your health and the purpose is not for personal reasons or convenience. Benefits include licensed air ambulance, when medically necessary as determined by Regence, to the nearest hospital equipped to provide the necessary treatment.

## Chemical Dependency Treatment

*Whenever reasonably possible, the facility should notify Regence at least 10 days before your chemical dependency treatment begins.*

Services of a participating facility are covered for inpatient and outpatient chemical dependency treatment — including detoxification, support services and drugs prescribed by the facility. Any chemical dependency benefits provided during the previous 24-month period under this or any other plan will be charged against the two-year benefit limit. Chemical dependency benefits exclude:

- Alcoholics Anonymous and similar chemical dependency programs
- Emergency service patrol who are trained in first aid and patrol areas
- Information referral services
- Information schools
- Long-term care or custodial care
- Tobacco cessation programs and supplies.

*You may also receive these benefits through King County's Making Life Easier Program by calling toll-free (888) 874-7290. Staff will obtain preadmission approval as necessary and refer you to a provider for treatment.*

## Chiropractic Care

This plan covers health care services performed by an approved chiropractor if the service is within the lawful scope of the chiropractor's license.

## Diabetes Care Training

Outpatient diabetic self-management training and education, including nutritional therapy, is covered if recommended by a participating provider with expertise in diabetes.

## Durable Medical Equipment, Prosthetics, Orthopedic Appliances

*Durable medical equipment must be ordered while your coverage is in effect and delivered within 30 days after coverage terminates.*

Rental (or purchase if approved by Regence) of durable medical equipment for therapeutic use includes crutches, wheelchair, kidney dialysis equipment, standard hospital beds, equipment for the administration of oxygen, and medically necessary diabetic equipment such as blood glucose monitors, insulin infusion devices and insulin pumps. Repair or replacement of durable medical equipment medically necessary due to normal use or growth of a child also is covered. "Durable medical equipment" means equipment that can withstand repeated use, whose only function is for treatment of the medical condition, and that is generally not useful in the absence of the condition.

The following items are not covered:

- Air conditioners or dehumidifiers
- Arch supports or casting for arch supports or corrective shoes
- Heating pads
- Enuresis (bed wetting) training equipment
- Hearing aids
- Exercise equipment or weights
- Whirlpool baths
- Eyeglasses
- Motorized equipment.

*The prosthesis must be ordered while your coverage is in effect and delivered within 30 days after coverage terminates.*

Prostheses are covered for functional reasons when replacing a missing body part, but not for cosmetic reasons (except medically necessary external and internal breast prostheses after a mastectomy; external breast prostheses are limited to 1 replacement every 3 years).

### *Special Items*

Covered items include:

- Casts, splints, braces, surgical and orthopedic appliances
- Colostomy bags and supplies
- Catheters
- Syringes and needles for insulin and allergy injections
- Dressings medically necessary for wounds, cancer, burns or ulcers
- Blood bank charges.

## Emergency Care

In a medical emergency, treatment by a participating provider or hospital not normally covered by the Regence Medical Plan will be covered for 24 hours — or the additional time reasonably required to come under the care of a participating provider. Benefits are based on the provider's actual charge for the service if the charges are reasonable and not increased because of this plan's coverage. (For a definition of emergency see page 55.)

Conditions that might require emergency care include, but are not limited to:

- Severe breathing problems
- Unconsciousness or confusion — especially after a head injury
- Bleeding that will not stop
- Major burns
- An apparent heart attack (chest pain, sweating, nausea)
- Convulsions.

## Family Planning

Family planning is generally not covered, but medical treatment will be provided for infertility the same as any other condition.

No benefits will be provided for expenses in connection with in-vitro fertilization, artificial insemination or embryo transfer procedures, infertility drugs (such as but not limited to Clomid, Pergonal, or Serophene), or other artificial means of conception. However, a pregnancy resulting from such conception will be covered under the regular maternity benefits of the plan as applicable.

## Growth Hormones

Benefits will be provided for growth hormone when furnished by a participating infusion therapy provider for growth hormone deficiency in children, Turners syndrome, growth failure in children secondary to chronic renal insufficiency, prior to renal transplant or for the promotion of wound healing in patients with sever acute burns. Growth hormone treatment of these conditions is covered when preauthorized.

## Home Health Care

*For certain illnesses or injuries, the Regence Individual Benefits Management staff will work with you and your provider to determine the treatment options that offer the most cost-effective or beneficial care in your specific case. In some instances, the Individual Benefits Management staff may authorize benefits that would not normally be covered under this plan; such authorization must be received in advance of the service being provided. The final decision on the course of treatment will rest with you and your provider.*

The services of a participating home health care agency are covered in your home if:

- You are homebound — which means leaving the home could be harmful, involving a considerable and taxing effort — and unable to use transportation without assistance
- Your condition is serious enough to require confinement in a hospital or skilled nursing facility in the absence of home health care services, and
- Your participating provider establishes or approves and reviews at least every 60 days a written treatment plan specifying the home health care services and supplies to be provided.

In your home, covered benefits are limited to the following services:

- Home health aide services by an aide providing part-time or intermittent care under supervision of an RN, licensed physical therapist, occupational therapist or speech therapist; includes ambulation and exercise, assistance with self-administered medications, reporting changes in your conditions and needs, completing records and personal care or household services needed to achieve medically desired results
- Medical social services by a person with a master's degree in social work
- Medical supplies dispensed by the home health care agency that would have been provided on an inpatient basis
- Nursing services by an RN or LPN
- Nutritional guidance by a registered dietitian
- Nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation
- Occupational therapy by an occupational therapist certified by the American Occupational Therapy Association

## Home Health Care (cont'd)

- Physical therapy by a licensed physical therapist
- Physician services
- Respiratory therapy by an inhalation therapist certified by the National Board of Respiratory Therapists
- Services and supplies for infusion therapy when performed and billed by the participating home health care agency or a participating infusion therapy provider (the patient does not need to be homebound)
- Services performed by employees of and billed by the participating home health care agency
- Speech therapy by an ASHA-certified speech therapist.

Home health benefits exclude:

- Custodial or maintenance care
- Financial or legal counseling
- Food, clothing, housing or transportation (except for the ambulance benefit on page 14)
- Homemaker or housekeeping services (except as described in the previous section)
- Services normally provided under a hospice program
- Services of volunteers, household members, family or friends
- Services or supplies not included in the written treatment plan, not specified as a covered benefit or excluded under this plan
- Services to other family members
- Supportive environmental materials, such as ramps, handrails or air conditioners.

## Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers.

If you are terminally ill, services of a participating hospice are covered for medically necessary treatment or palliative care (relief of pain and other symptoms), subject to the conditions and limits described below.

Your participating provider must establish or approve and review at least every 60 days a written treatment plan specifying the hospice services and supplies to be provided.

*When you're confined as an inpatient in a participating hospice that is not a participating hospital or skilled nursing facility, the same benefits available in your home are covered, in addition to a semiprivate room. The services must be provided by employees of and billed by the participating hospice. This inpatient benefit is limited to 14 days during the 6-month hospice benefit period.*

In your home, covered hospice services are limited to:

- Home health aide services by an aide providing part-time or intermittent care under supervision of an RN, licensed physical therapist, occupational therapist or speech therapist; includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing records and personal care or household services needed to achieve medically desired results
- Medical social services by a person with a master's degree in social work
- Medical supplies dispensed by the hospice that would have been provided on an inpatient basis
- Nursing services by an RN or LPN
- Nutritional guidance by a registered dietitian
- Nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation
- Occupational therapy by an occupational therapist certified by the American Occupational Therapy Association
- Physical therapy by a licensed physical therapist
- Physician services
- Respiratory therapy by an inhalation therapist certified by the National Board of Respiratory Therapists

## Hospice Care (cont'd)

*Respite care provides temporary relief to family members or friends from the duties of caring for the patient.*

- Respite care for a minimum of 4 or more hours a day
- Services and supplies for infusion therapy when performed and billed by the participating hospice or a participating infusion therapy provider
- Services performed by employees of and billed by the participating hospice
- Speech therapy by an ASHA-certified speech therapist.

Hospice benefits are limited to:

- Respite care of 4 or more hours a day when no skilled care is required, up to a combined total of 120 in each 3 months of the 6-month total
- Visits of 4 or more hours when skilled care is required by an RN, LPN or home health aide, up to a combined total of 120 hours.

Hospice benefits exclude:

- Custodial or maintenance care (except for palliative care to a terminally ill patient as described above)
- Financial or legal counseling
- Food, clothing, housing or transportation (except for the ambulance benefit on page 14)
- Homemaker or housekeeping services (except as described in the previous section)

*Your participating provider must establish or approve and review at least every 60 days a written plan of care specifying the hospice services and supplies to be provided.*

- Services of volunteers, household members, family or friends
- Services or supplies not included in the written treatment plan, not specified as a covered benefit or excluded under this plan
- Services to other family members
- Spiritual counseling or bereavement counseling
- Supportive environmental materials, such as ramps, handrails or air conditioners.

## Hospital Care

*You must obtain preadmission approval for inpatient treatment. See page 11.*

Preauthorized inpatient and outpatient hospital services are covered for injury and illness (including services of staff physicians billed by the hospital). Room and board is limited to the hospital's average semiprivate room rate.

### *Hospitalization for Dentistry*

Provider and hospital inpatient services are covered when medically necessary, but no benefits are provided under the Regence Medical Plan for:

- Administration of or cost of anesthesia
- Charges by a dentist (except as described in the following section)
- Hospitalization or appliances for malocclusions or other abnormalities of the jaw, including temporomandibular joint disorders or myofascial pain syndrome.

## Infertility

Medical treatment will be provided for infertility the same as any other condition.

The plan does not cover:

- In-vitro fertilization
- Artificial insemination
- Embryo transfer procedures
- Infertility drugs (such as, but not limited to Clomid, Pergonal, or Serophene)
- Other artificial means of conception. However, a pregnancy resulting from such conception will be covered under the maternity benefits as applicable.

## Injury to Teeth

Services of a licensed dentist or denturist and related hospital expenses are covered for repair of accidental injury to sound, natural teeth for 12 consecutive months after the date of injury, up to $600 per occurrence. Injuries caused by biting or chewing are not covered under the Regence Medical Plan. Treatment must begin within 30 days of the accident. Payment is based on the allowed amount, and any additional charges are your responsibility. You must be continuously covered by this or a prior Regence plan from the date of injury.

## Inpatient Care Alternatives

Inpatient care alternatives are not available under the Regence Medical Plan.

## Lab, X-rays and Other Diagnostic Testing

Lab and x-ray services are covered, including screening and diagnostic mammography services, if recommended by the following participating providers:

- Physician
- Advanced RN practitioner
- Licensed physician assistant.

## Manipulative Therapy

See "Chiropractic Care" on page 14.

## Maternity Care

*Benefits for women's health care services are covered if provided by:*

- *Participating providers*
- *Approved advanced RN practitioners specializing in women's health and midwifery*
- *Approved provider's assistants.*

Covered maternity care expenses include prenatal and postnatal treatment of pregnancy and normal or cesarean delivery as well as voluntary termination of pregnancy.

Benefits for any hospital length of stay due to childbirth for the mother or newborn cannot be limited to less than 48 hours for a vaginal delivery or 96 hours for a cesarean section. However, the health care provider, after consulting with the mother, may discharge the mother or newborn before the 48 or 96 hours. These maternity benefits are not available for dependents.

Maternity services are treated the same as any other illness or injury. Complications arising from pregnancy are covered as any other condition. Complications of pregnancy include, but are not limited to, diabetes if onset is after conception, fetal distress and toxemia. Charges for false labor or voluntary termination of pregnancy are not covered.

*Covered women's health care services include:*

- *Maternity care*
- *Reproductive health services*
- *Gynecological care*
- *General exams*
- *Preventive care.*

Covered expenses also include prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy, when medically necessary in accordance with Washington State Board of Health standards.

## Mental Health Care

Mental health care is covered when you're confined as an inpatient in a participating hospital or psychiatric hospital, a state mental hospital or a licensed community mental health agency with an inpatient facility.

*You must obtain preadmission approval for inpatient mental health care. See page 11.*

Anorexia nervosa, bulimia or any similar condition is covered only for counseling under this benefit.

Outpatient mental health care is covered when provided by one of the following providers:

- Psychologist
- Mental Health Counselor

- Masters of Social Work
- Licensed Community Mental Health Agency.

You may also receive these benefits through King County's Making Life Easier Program by calling toll-free (888) 874-7290. Staff will obtain preadmission approval as necessary and refer you to a provider for treatment.

## Neurodevelopmental Therapy

*You must obtain preadmission approval for inpatient neurodevelopmental treatment.* *See page 11.*

Neurodevelopmental therapy treatment is covered if performed to restore and improve function for children age 6 and under. This benefit also includes maintenance services where significant deterioration of the patient's condition would result without the service. Benefits include:

- Inpatient hospital and skilled nursing facility benefits for an inpatient neurodevelopmental therapy admission when care cannot safely be provided on an outpatient basis; hospital services must be received in a hospital approved for rehabilitative care
- Services of a provider, a hospital approved for rehabilitative care, a licensed physical therapist for physical therapy, a certified speech therapist for speech therapy or a licensed occupational therapist for occupational therapy — in the office, home or hospital outpatient department.

A covered child will not be eligible for the rehabilitative services benefit and this benefit for the same condition.

*Your provider must submit for advance approval and review at least every 60 days a written treatment plan specifying the neurodevelopmental therapy services to be provided.*

Neurodevelopmental therapy benefits exclude:

- Alcohol, drug or chemical substance abuse rehabilitation
- Custodial care
- Gym or swim therapy
- Mental health care

- Nonmedical self-help, recreational or educational or vocational therapy.

## Newborn Care

The plan covers newborns under the mother's coverage for the first 3 weeks, as required by Washington state law.

To continue the newborn's coverage after 3 weeks, the newborn must be eligible and enrolled by the deadline described in "Making Changes" on page 3.

## Physician and Other Medical and Surgical Services

The plan covers:

- Immunization agents or biological sera, such as allergy serum
- Medical care in the provider's office
- Nutritional counseling by a registered nutritionist or dietitian when medically necessary for disease management
- Provider services for surgery, anesthesia, inpatient and emergency room visits
- Second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training)

## PKU Formula

The plan covers medical dietary formula that treats phenylketonuria (PKU).

## Prescription Drugs

*Prescriptions are limited to a 34-day supply or 100 units/ purchase, whichever is greater.*

Drugs requiring a prescription by federal or state law are covered when dispensed by a licensed pharmacist to treat a covered condition. Insulin dispensed by a participating provider or certified lab also is covered. FDA-approved drugs used for off-label indications are covered only if

recognized as effective for treatment in a standard reference compendium, in most relevant peer-reviewed medical literature or by the federal Secretary of Health and Human Services. Drugs the FDA has determined to be contra-indicated are not covered.

## Preventive Care

The following preventive care services are covered on an outpatient basis as any other illness or condition, including women's health care services, and must be recommended by your participating provider:

- Office calls and related lab and x-ray services for cancer screening
- Pediatric and adult immunizations
- Routine pediatric and adult physical exams
- Routine well-baby care from birth.

## Radiation Therapy, Chemotherapy, and Respiratory Therapy

Radiation therapy and chemotherapy are covered.

Services for respiratory therapy are covered under the Home Health Care, Hospice Care and Hospital Care benefits.

## Reconstructive Services

Reconstructive surgery will be provided:

- When related to an illness or injury occurring while covered under this plan
- For congenital anomalies when the patient has been covered under this plan from birth.
- For reconstructive breast surgery and associated procedures, following a mastectomy (regardless of when the mastectomy was performed) and determined in consultation with the patient and attending physician including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the healthy breast to produce a symmetrical appearance
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

For more information on the level of benefits you receive refer to "Medical Plan Summary" starting on page 5.

## Rehabilitative Services

The benefits described below are covered for rehabilitative care to restore and improve function previously normal but lost due to illness or injury. Benefits are also provided for treatment of congenital anomalies of a newborn covered from birth.

The plan covers:

*You must obtain preadmission approval for inpatient rehabilitative treatment. See page 11.*

- Inpatient hospital and skilled nursing facility expenses for physical, speech or occupational therapy if you have been continuously covered under this or a prior medical plan with Regence from the onset of the condition. Hospital services must be received in a hospital approved by Regence for rehabilitative services, and treatment must occur within 3 years from the date of your first hospital or skilled nursing facility rehabilitative care admission while covered by a Regence plan. At least every 60 days, your provider must submit for approval and review a written treatment plan specifying the rehabilitative services to be provided. This must be submitted before treatment is received, except in emergencies.
- Physical or speech therapy in the office, home or hospital outpatient department is covered if performed by an approved provider for physical and speech therapy only or a hospital approved for rehabilitative care. The initial claim must be submitted with the provider's prescription for the rehabilitative services.

Rehabilitative benefits exclude:

- Chemical dependency rehabilitative treatment

- Custodial care
- Gym or swim therapy
- Learning disabilities or developmental delay
- Maintenance care
- Mental health care
- Nonmedical self-help
- Recreational, educational or vocational therapy.

## Skilled Nursing Facility

*You must obtain preadmission approval for inpatient skilled nursing treatment. See page 11.*

Room and board is limited to the facility's average semiprivate room rate. You must have been hospitalized in an approved hospital for at least 5 consecutive days and admitted directly to the skilled nursing facility for treatment of the same condition. You must be receiving therapeutic treatment that could not be administered in the home by a friend or relative. No custodial or maintenance care is provided.

## Smoking Cessation

The services of a participating physician, approved psychologist or participating smoking cessation provider will be provided for a smoking cessation program. To receive benefits for smoking cessation, you must complete the full course of treatment. No benefits will be provided for:

- Acupuncture
- Books or tapes
- Hypnotherapy unless performed by an approved provider
- Inpatient services
- Over-the-counter drugs or prescription drugs prescribed by your covered provider to ease nicotine withdrawal
- Vitamins, minerals and other supplements.

No other benefits for smoking cessation will be provided under this plan.

## Sterilization Procedures

Sterilization procedures are covered.

## Supplemental Accident Benefits

Treatment must begin within 30 days of the accident (and is covered to a maximum of 12 consecutive months after the date of the injury) to $600 per occurrence. If treatment continues beyond 12 months, the deductible will apply and the plan pays benefits as any other illness or injury.
You must be continuously covered by this or a prior Regence plan from the date of injury. Benefits include:

- Charges of a participating hospital or participating skilled nursing facility; room, board and general nursing care are limited to the facility's or hospital's average semiprivate room rate
- Drugs requiring a prescription by federal or state law
- Necessary durable medical equipment and special items including casts, splints, braces, prostheses, surgical and orthopedic appliances, surgical dressings and oxygen
- Services of a participating provider, licensed dentist or denturist for repair of sound, natural teeth (this benefit will not be provided for injury caused by biting or chewing)
- Ambulance services.

## TMJ

Expenses related to services for temporomandibular joint (TMJ) disorder are not covered under the Regence Medical Plan.

## Transplants

Benefits are covered as described below for medically necessary services related to a transplant, subject to certain conditions and limitations (contact Regence for details).

*You must obtain preadmission approval for transplant services.*

A transplant recipient covered under this plan is eligible for the following transplants:

- Bone marrow, including associated high-dose chemotherapy for certain conditions (contact Regence for details)
- Cornea
- Heart
- Heart/lung (combined)
- Kidney
- Kidney/pancreas (combined)
- Liver

## Transplants (cont'd)

- Lungs — single/bilateral/lobar
- Small bowel
- Small bowel/liver.

Travel and lodging for the patient and patient's family are covered when Regence approves it and requires travel outside the area for an approved transplant.

*If a transplant is not successful, a retransplant will be covered, also subject to the limits in this section.*

Transplant benefits exclude:

- Coverage when donor benefits are available through other group coverage
- Coverage when government funding of any kind is provided
- Donor and procurement costs incurred outside the United States, unless approved
- Investigational procedures
- Living donor transplants (except kidney)
- Lodging, food or transportation, unless otherwise specifically provided under this plan

- Nonhuman, artificial or mechanical transplants
- Services in a facility not approved by Regence.

## Urgent Care

*See page 36 for instructions on what to do if you need urgent care.*

This plan covers urgent care, which is treatment for conditions that are not life threatening but may need immediate attention, for example:

- Ear infections
- High fevers
- Minor burns.

Urgent care isn't treated any differently than other care. Generally, urgent care involves an office visit and is paid at various levels; call the plan for details.

## Vision Care

One eye exam each year is covered to determine the need for a new or changed lens prescription. This exam is paid at 100% if performed by a participating provider or participating optometrist.

The costs of lenses and frames are reimbursed as shown below if prescribed by an approved provider. Contact Regence for a current list of providers.

*You don't need to meet the annual deductible before vision benefits are payable.*

Lenses — allowance (maximum of 2 separate lenses a calendar year):

| | |
|---|---|
| Single vision | $20/lens |
| Bifocal | $30/lens |
| Trifocal | $40/lens |
| Lenticular or aphakic (external lens requiring a frame) | $65/lens |
| Contacts — medically necessary* | $100/lens |
| Contacts — cosmetic | $20/lens |
| Frames — maximum every 2 calendar years | $30 |

* Contacts are considered medically necessary only if your vision is correctable to 20/70 or better only by the use of contact lenses or in the case of aphakia.

## EXPENSES NOT COVERED

In addition to the limitations and exclusions described in this booklet, the Regence Medical Plan does not cover:

- Acupuncture
- Addiction to or abuse of drugs, alcohol or any other chemical substance whether legal or illegal except as specifically provided (see "Chemical Dependency Treatment" on page 14)
- (Except as otherwise required by law) benefits payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage or similar contract or insurance
- Charges above the allowed amount

## EXPENSES NOT COVERED (cont'd)

- Charges no one is obligated to pay
- Conditions related to military service or war
- Contraceptive drugs or devices
- Cosmetic surgery, except:
  - When related to an illness or injury occurring while covered under this plan
  - For congenital anomalies when the patient has been covered under this plan from birth
  - For reconstructive breast surgery and associated procedures, following a mastectomy (regardless of when the mastectomy was performed) and determined in consultation with the patient and attending physician including:
    - Reconstruction of the breast on which the mastectomy has been performed
    - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance

  - Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

- Custodial care
- Dentistry and dental x-rays, except as specifically provided in "Hospitalization for Dentistry" (see page 22) and "Injury to Teeth" (see page 23)
- Drugs approved by the FDA but used for off-label indications will be covered only if recognized as effective for treatment:
  - In one of the standard reference compendia
  - In the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia or
  - By the federal Secretary of Health and Human Services

  (no benefits will be provided for any drug when the FDA has determined its use to be contra-indicated)
- Equipment, supplies, prostheses, appliances, braces or foot care appliances except as specifically provided (see "Durable Medical Equipment" on page 15)
- Except as required by law, benefits that are covered or would be covered without this plan, by:
  - A government-owned or operated institution (except facilities included on the list of participating providers or when otherwise required by law for emergency services or coverage provided by Medicaid)
  - Medicare or any federal, state or government program
- Foot impression casting
- Hearing aids and cochlear implants
- Hospitalization for minor conditions such as common colds and removal of small tumors
- Injuries related to semiprofessional or professional athletics, including practice

- Investigational services or supplies
- In-vitro fertilization, artificial insemination, embryo transfer, fertility drugs (such as Clomid, Pergonal, Serophene) or any other artificial means of conception
- Marital and family counseling
- Mental health treatment for anorexia nervosa, bulimia or other eating disorders, except as specifically provided in "Mental Health Care" (see page 24)
- Neurodevelopmental therapy, except as specifically provided (see "Neurodevelopmental Therapy" on page 25)
- Obesity treatment
- Occupational injury or disease when covered by state industrial insurance, Workers Compensation or any federal act (employees covered under LEOFF I will be covered under this plan for nonoccupational injuries or injuries connected with their occupation as King County Deputy Sheriff officers)

## EXPENSES NOT COVERED (cont'd)

- Rehabilitative care, except as specifically provided in "Rehabilitative Services" (page 28)
- Routine physical examinations, except as specifically provided in "Preventive Care" (see page 27)
- Services and supplies not medically necessary for treatment of an illness or injury, unless otherwise listed as covered
- Services provided by a family member
- Services provided by the group or any of its employees or agents
- Sexual dysfunction or transsexualism surgery or treatment; impotence; medications for sexual dysfunction including impotence, for example Viagra

- Treatment for malocclusion or other abnormalities of the jaw, including services for temporomandibular joint (TMJ) disorders
- Vision care, except as specifically provided in "Vision Care" (see page 32)
- Visual analysis, therapy or training; orthoptics.

## SPECIAL SITUATIONS

### If You Need Emergency Care

*Emergency is defined on page 55.*

If you need emergency care, follow these steps:

- Dial 911 or go to the nearest hospital emergency room immediately.
- When you arrive, show your identification card.
- If you're admitted, call your plan within 24 hours; otherwise, you may be responsible for all costs incurred before you call. If you're unable to call, have a friend, relative or hospital staff call for you. The plan's telephone number is printed on the back of your identification card.

If you have an emergency as determined by Regence, benefits are paid as described in the "Medical Plan Summary." Follow-up care received or coordinated through your primary care provider will be paid as any other care.

### If You Need Urgent Care

Sometimes you may need to see a provider for conditions that are not life threatening but need immediate medical attention.

- For urgent care during office hours, call your provider's office for assistance.
- After office hours, call your provider's office and leave your name and number; the provider on call will call you

back. Depending on your situation, the provider may provide instructions over the phone, ask you to come into the office or advise you to go to the nearest emergency room.

## If You Need Care While Traveling

*If you need care while traveling, contact your provider for guidance.*

If you are traveling outside the service area and need medical attention, you may see any licensed provider and receive benefits from the plan. Benefits are payable up to the allowed amount. However, if you receive care from a participating provider, you'll receive the discounted fee and the provider will file your claims. Call Regence for a list of participating providers in the area you're traveling. If you are admitted as an inpatient while traveling outside the service area, you should notify Regence of your hospitalization.

No benefits will be provided when you leave your state of residence for the purpose of obtaining care for any condition unless medically necessary.

## If Your Family Member Lives Away From Home

If you or a family member lives outside the service area, benefits are paid as if you lived within the service area. You may see any licensed provider and receive benefits from the plan. However, if you receive care from a participating provider, you'll receive the discounted fee and the provider will file your claims.

## If You Take a Leave of Absence

You must contact Employee Benefits and Well-Being to arrange to continue your medical coverage during a leave of absence. Your coverage will continue (at the cost you currently pay, if any) for the periods established by your collective bargaining agreement.

## If You Leave Employment to Perform Military Service

If you leave employment to perform uniformed service (such as service in the military), you may continue medical

coverage for up to the shorter of 18 months or the period of your service under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Generally, you must pay the full cost of coverage. To be eligible, you must meet the requirements under USERRA. Contact Employee Benefits and Well-Being for more information. The Veterans Employment and Training Administration is also required to assist you.

*If you don't arrange to continue coverage, it will end on the last day of the month you leave employment.*

You must give Employee Benefits and Well-Being written notice when you leave employment covered by this plan to perform uniformed service. You must also give Employee Benefits and Well-Being written notice when you return after your uniformed service to employment covered by this plan.

## If You Enter Into a Labor Dispute

If your pay is suspended directly or indirectly as a result of strike, lockout or other labor dispute, you may continue medical coverage for up to 6 months for yourself and your eligible family members if you pay the full cost of medical coverage directly to Employee Benefits and Well-Being. At the end of 6 months, you may be eligible for up to 12 more months of coverage under COBRA; see page 46 for details.

## If You Are Laid Off

If you are laid off while a participant in this plan, medical coverage for you and your eligible family members may continue for a limited time by paying the full cost of coverage. See "Continuation of Coverage (COBRA)" on page 46.

If you return to work as an eligible employee within 24 months of the date you were laid off, coverage begins the first of the month following your return. If you return after 24 months, you will be considered a newly hired employee.

## If You Die

If you die while a participant in this plan, medical coverage for your eligible family members may continue for a limited time if they pay the full cost of coverage. See page 46 for details.

## If You Become Disabled

If you or covered family members participating in this plan are totally disabled and your coverage ends for any reason except plan termination, medical coverage — for the disabling condition only — may be extended for 12 months at no cost to you. You may choose either this medical extension or COBRA coverage. If you elect this extension, you forfeit your right to elect COBRA coverage and your right to convert to an individual policy.

*Contact Employee Benefits and Well-Being for more information.*

If the plan described in this booklet is terminated, the extension coverage will end on that date. Extension coverage will also end on the date you or your family members:

- Reach any lifetime maximum that may apply
- Are no longer disabled
- Become eligible for benefits under another group policy or
- Reach the end of the 12-month extension.

## If You Retire

If you retire before age 65, you may continue your coverage under COBRA as described on page 46. Contact Employee Benefits and Well-Being for eligibility requirements.

# FILING A CLAIM

*If you're covered by Medicare and Medicare is your primary coverage, you must submit the Medicare Explanation of Benefits form in addition to the claim form and itemized bill.*

## Participating Providers

Be sure to present your identification card when receiving treatment. It is not necessary for you to file claims for services of participating providers, including hospitals. If you receive a bill from your provider or hospital, please verify with the provider or hospital that Regence has been billed. At the time of service, you should inform your provider about copays that are required on your plan. Arrangements for paying copays should be handled directly between you and your provider.

## Non-Participating Providers

To submit your own claims, request a claim form from Regence and submit 2 copies of the itemized bill with the following information:

- Covered employee's name, address, Social Security number, group name and number
- Patient's name and birth date
- Diagnosis or nature of illness
- Itemized bills including amount and date of each item on the provider's, facility's or other provider's letterhead or statement showing the provider's tax identification number
- For drug claims, a prescription drug form and itemized drug receipts (not cash register receipts)
- For medical equipment and supplies, the date of purchase or beginning and ending dates of rental, name of referring provider and whether it's an initial purchase or a replacement and why replaced; a signed authorization from the provider also is required specifying duration of need.

*To report the fraudulent use of someone else's identification card, charges that don't reflect actual treatment, a person submitting false claims or someone using false eligibility information, you can call Checkup at (800) 922-4325 in strict confidence, Monday through Friday from 9:00 a.m. to 4:00 p.m.*

Send your claim to:

Regence Medical Plan
PO Box 21267
Seattle WA 98111-3267

All claims must be submitted within 15 months of the date of service. However, if your coverage terminates, all claims must be submitted within 6 months of that date. Claims not submitted within this time limit will not be paid.

## APPEALING A CLAIM

*If your claim is denied in whole or in part, you will be notified in writing of the reason for the denial within 30 days from the date you filed your claim. The notice will include information required if you want to appeal.*

You may appeal a denied claim within 90 days of the date you receive the denial notice. This procedure is the only means available to change a benefit decision. To appeal, write to the plan and state the reasons you believe your claim should have been paid. Include any additional documentation to support your claim. You also may submit questions or comments you think are appropriate, and you may review relevant documents.

Normally, you will receive a written decision on your appeal within 60 days of the date the plan receives your request. If special circumstances require a delay, you will be notified of the extension during the 60 days after receipt of your request.

If you have an appeal regarding the denial of benefits for investigational or experimental services, the plan will provide a written explanation within 20 working days of receiving the request for an appeal (unless the plan determines a 20-day extension is warranted due to extenuating circumstances regarding the review process).

## RELEASE OF MEDICAL INFORMATION

When you join this plan, you authorize the plan to receive and release information concerning your claims when necessary. In administering benefits, the plan may need to contact your provider or other person, organization or insurance company to obtain or release information such as medical records.

## PHYSICAL EXAM

Regence, at their own expense, may have a provider examine the covered patient when an injury or sickness is the basis of a claim. The plan may examine the patient as often as necessary while the claim is pending.

## QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

In accordance with applicable law, the plan provides medical coverage to certain children of yours (called "alternate recipients") if directed by certain court or administrative orders. These include a decree, judgment, or order from a state court (including approval of a settlement agreement) or administrative order that requires these plans to include a child in your coverage and make any applicable payroll deductions.

A medical child support order is generally considered qualified and enforceable if it specifies:

- Employee name and last known address
- Each alternate recipient's name and address
- A description of the coverage the alternate recipient will receive
- Each plan subject to the order.

When the county receives a medical child support order, we promptly notify you and the alternate recipient that the order has been received and what procedures will be used to determine if the order is qualified. Once the decision is made, we will notify you and the alternate recipient(s) by mail.

## COORDINATION OF BENEFITS

If you or your family members have additional health care coverage, benefits from the other plan(s) may be considered before benefits are paid under this plan. Additional coverage includes another employer's group benefit plan or other group arrangement — whether insured or self-funded.

*In no case will you receive more than 100% of the covered expense.*

The plan that must pay benefits first is considered primary and will pay without regard to benefits payable under other plans. When another plan is primary, Regence will coordinate benefits so you receive maximum coverage (the highest allowable benefit).

*If you or your family members are covered under another plan, be sure to keep a copy of your itemized bill and send the bill and Explanation of Benefits to Regence.*

If the other plan does not have a coordination of benefits provision, that plan will pay first. If it does, the following rules determine payment:

- The plan covering an individual as an employee will pay first.
- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, the other plan's provisions will apply.)
- If the parents are divorced or legally separated, these rules apply:
  - If the parent with custody (or primary residential placement) has not remarried, the plan of that parent pays before the plan of the parent without custody
  - If the parent with custody has remarried, the plan that covers the child is determined in this order:

plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody

- If the court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility will pay first.

## COORDINATION OF BENEFITS (cont'd)

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed will pay first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

Regence has the right to obtain and release data as needed to administer these coordination procedures. For example, if the plan paid too much under the coordination of benefits provision, it has the right to recover the overpayment from you or your provider.

## COORDINATION OF BENEFITS WITH MEDICARE

If you continue to work for the county after age 65, you may:

- Continue your medical coverage under the county plan and integrate the county plan with Medicare (the county plan would be primary or pay benefits first)
- When eligible for Medicare, active employees as well as spouses age 65 and over may elect this medical plan or Medicare as primary coverage, under the Tax Equity and Fiscal Responsibility Act of 1982. If Medicare is selected as primary coverage, this medical plan is not available. Contact Employee Benefits and Well-Being for details.

*If you have any questions about how your coverage coordinates with Medicare, contact Employee Benefits and Well-Being.*

- Discontinue this coverage and enroll in Medicare. (Federal regulations prohibit employer plans from being secondary for active participants.) If you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months. See "Continuation of Coverage (COBRA)" on page 46 for details.

## WHEN COVERAGE ENDS

### Employees

Your medical coverage ends on the last day of the month in which you:

- Are no longer eligible as defined on page 1
- Resign, retire or are terminated.

Your medical coverage also ends on the day:

- This plan terminates
- You die.

### Retirees

Retirees are not eligible for this plan.

### Family Members

Your family members' medical coverage ends on the last day of the month in which your:

- Coverage ends
- Family member is no longer eligible as defined on page 2.

Your family members' medical coverage also ends on the day:

- This plan terminates

- Your family member dies.

## CERTIFICATE OF COVERAGE

When your coverage under this plan ends, you will automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan. You will need to do this only if the other health plan has a preexisting condition limit.

## CONTINUATION OF COVERAGE (COBRA)

*To continue coverage, you or your family members must elect COBRA coverage and pay the required premium before the payment deadline.*

Continued medical coverage may be available to you and your covered family members under COBRA if coverage ends because of a qualifying event (described below).

### Eligibility

You and your covered family members are eligible for up to 18 months of COBRA coverage if you lose coverage because your:

- Employment ends for reasons other than gross misconduct or
- Work hours are reduced to the point where you no longer are eligible for benefits.

If you or your family member who is a qualified beneficiary is determined to be Social Security disabled at the time of one of the above qualifying events (or at any time within the first 60 days of continuation coverage), you and your family members are eligible for up to a total of 29 months of COBRA coverage. Employee Benefits and Well-Being must receive a copy of your Social Security Disability approval letter before the end of the first 18-month continuation period and within 60 days after the date of the Social Security Administration determination.

*If a second qualifying event occurs during a continuation period, your family members may continue coverage up to a total of 36 months from the first qualifying event.*

Covered family members who are qualified beneficiaries are eligible to continue coverage up to a total of 36 months if coverage ends because of any of these qualifying events:

- Your death
- Your divorce or legal separation
- The loss of dependent-child status
- Your entitlement to Medicare.

## How to Apply

*If you gain a family member while participating in COBRA, the usual plan rules for enrolling family members will apply. See "Enrolling in the Plan" on page 3 for details.*

If you and/or your family member(s) lose medical coverage as a result of termination or reduction of hours, your death or Medicare entitlement, Employee Benefits and Well-Being will notify you and/or your family member(s) of your options. If your family member will lose coverage because of divorce, legal separation or a child losing eligibility, you or your family member must notify Employee Benefits and Well-Being within 60 days of the qualifying event or the date coverage ends, if later. Otherwise, your family member's right to continue coverage under COBRA ends.

When your current coverage is scheduled to end, you and your family members will receive details about COBRA. To continue coverage, you must elect COBRA within 60 days after the later of loss of coverage because of a qualifying event or the date of your notice of eligibility to continue coverage.

### Paying for COBRA Coverage

*Employee Benefits and Well-Being will give you payment amounts and deadlines.*

You or your covered family members must make the initial payment within 45 days of the date you elect to continue coverage. Because COBRA coverage is retroactive to the day coverage ended, your initial payment must include all applicable back premiums.

You must keep paying the cost of COBRA coverage on time or it automatically ends.

### When COBRA Coverage Ends

COBRA coverage ends when you or your family members:

*COBRA coverage also ends if King County terminates the plan and no longer provides medical benefits to active employees.*

- First become covered under another group health plan after the date of your COBRA election, unless that plan limits or excludes coverage for a preexisting condition of the individual continuing coverage
- Fail to make the required payments within 30 days of the due date
- First become entitled to Medicare benefits after the date of your COBRA election
- Reach the end of the maximum COBRA coverage period or
- Are no longer disabled as determined by the Social Security Administration.

## CONVERTING YOUR COVERAGE

*Contact Employee Benefits and Well-Being for conversion forms and more details. You will not receive this information unless you request it.*

If you are no longer eligible for the medical coverage described in this booklet, you may convert your coverage. The plan you convert to will differ from the benefits described in this booklet. You must pay premiums, which may be higher than any amounts you currently pay for these benefits.

You will not be able to convert to the individual policy if you:

- Are eligible for any other medical coverage under any other group plan
- Have reached the lifetime maximum benefit.

To apply for a conversion plan, you must complete and return an application form to the plan within 31 days after your medical coverage terminates. Evidence of insurability will not be required.

## Medicare Supplement

If you are age 65 or older, are eligible for Medicare and wish to convert your coverage, you may apply for coverage under one of Regence's Medicare Supplement plans. To be eligible for continuous coverage, Regence must receive your application within 31 days following termination of coverage under this plan. If you apply for Medicare Supplement coverage within 6 months of turning age 65 or enrolling in Medicare Part B, no health statement will be required. After the 6-month enrollment period, a health statement may be required. Benefits and rates under the Medicare Supplement plan will be substantially different from this plan. Benefits under the Medicare Supplement plan may be subject to waiting periods; however, any time you were continuously covered under this or any prior medical plan with Regence will be credited against Medicare Supplement plan waiting periods, if the Medicare Supplement plan replaces this plan.

## Individual Plan

If you are under age 65 and are not eligible for Medicare you may apply for coverage under one of Regence's regular individual plans. To be eligible, you must submit a completed application form and be accepted by Regence for coverage. Benefits and rates under the individual plan may be substantially different from this plan. If you transfer from this plan to an individual plan without a lapse in coverage of more than 3 months, credit will be given for any waiting periods satisfied under this plan.

## EXTENSION OF COVERAGE

If this medical plan is canceled, it will continue to cover any participants who are hospital inpatients on the date the plan is terminated. Coverage will end on the date of discharge or when you reach the plan maximums — whichever comes first.

## ASSIGNMENT OF BENEFITS

Plan benefits are available to you and your covered family members only. The right to payment under this plan is not subject to attachment or garnishment and the plans will not honor any assignment of benefits to anyone.

In paying for services, the plan may make the payment to you, the provider or another carrier. The plan will also make payments on behalf of an enrolled child to his or her non-enrolled parent or a state Medicaid agency when required to do so by federal or state law. In these cases, the plan also has the right to make payment jointly.

All payments are subject to applicable federal and state law and regulation. Payments made according to this section will discharge the plan to the extent of the amount paid, so that the plan will not be liable to anyone aggrieved by the choice of payee.

## THIRD PARTY CLAIMS

If you receive benefits for any condition or injury for which a third party is liable, the plan may have the right to recover the money paid for benefits. This means the plan is not obligated to pay for services necessary because of an injury or condition for which you may have other recovery rights unless or until you (or someone legally qualified and authorized to act for you) promise in writing to:

- Include those amounts in any claim you or your representative makes for the injury or condition
- Repay the plan those amounts to the extent the proceeds of your recovery for the injury or condition exceed the total loss, prorating any attorneys' fees incurred in the recovery
- Cooperate fully with the plan in asserting plan rights — supplying any and all information and executing any and all documents reasonably needed for that purpose.

Any sums collected by or on behalf of you or your covered family members by legal action, settlement or otherwise — on account of benefits provided under this plan — are payable to the plan only after and to the extent the sums exceed the amount required to fully compensate you for your loss.

## RECOVERY OF OVERPAYMENTS

The plan has the right to recover amounts paid that exceed the amount for which the plan is liable. This amount may be recovered from 1 or more of the following (to be determined by the plans): any persons to or for or with respect to whom such payments were made, any other insurers, any service plans or any organizations or other plans. These amounts may be deducted from your future benefits (or your family members' benefits, even if the original payment was not made on that family member's behalf).

The plan's right of recovery includes benefits paid in error due to any false or misleading statements made by you or your family members.

## PAYMENT OF BENEFITS

The medical benefits offered in this booklet are funded by the plan, not the county (this is not a self-funded plan). This means the medical plan is financially responsible for claim payments and other plan costs.

## TERMINATION AND AMENDMENT OF THE PLAN

The county fully intends to continue plan benefits indefinitely, but also reserves the absolute right to amend or terminate the plan for any reason at any time. If the county terminates the plan, bona fide claims incurred before termination will be paid.

## DEFINITIONS

To help you better understand your medical benefits, here's a list of important definitions.

**Allowed Amount**

*Inside the service area:* For a service or supply, the amount determined by Regence to be an appropriate payment under an agreement between Regence and the provider. If no agreement exists between Regence or with one or more of the companies merged into Regence and the provider, the allowed amount is what Regence would have paid to a participating provider for like services or supplies under this plan. You will be responsible for any additional charges.

*Outside the service area:* For a service or supply, the amount, as determined by Regence, either by the local Blue Shield plan or by an independent entity selected by Regence. You will be responsible for any additional charges.

**Annual Deductible**

The amount Regence Medical Plan participants pay toward covered expenses each year before the plan pays benefits.

**Annual Out-of-Pocket Maximum**

The most participants pay toward coinsurance and copays each year.

**Approved Provider**

Means any of the following:

- Out-of-Area Provider — A provider outside the service area acting within the scope of that provider's license, who belongs to a category of providers whose services or supplies would be covered under this plan as benefits if furnished in the service area. The out-of-area provider must have the qualifications and license or certification equivalent to the qualifications and license or certification required for the comparable provider category inside the service area. In Washington or Oregon, an out-of-area provider must have signed a participating agreement with the local county medical bureau or with Regence BlueCross BlueShield of Oregon. If no such participating agreement is available in a particular area for a particular provider category, the provider must have the license or certification equivalent to that required for a participating provider. Outside Washington, an approved home health agency or hospice agency must be certified as such by Medicare.

- Participating Provider — A provider whose name is included in the current list of participating providers for this plans as prepared by Regence and provided to the group and who has entered into a current participating agreement with Regence.

- Recognized Provider — A provider in the service area, acting within the scope of that provider's license, who belongs to a category of providers for which participating agreements are not available, and for whose services this plan provides certain benefits, except for medical emergencies and except as specifically stated in the Benefits section of this booklet. For medical emergencies, recognized provider means a provider in the service area who is not a participating provider.

**Brand-Name Drugs**

Trademark drugs patented for a limited period by a single pharmaceutical company.

| | |
|---|---|
| **Certificate of Coverage** | A document that provides evidence of prior health plan coverage. Under the Health Insurance Portability and Accountability Act, when a participant's coverage ends, he or she is entitled to receive a certificate of health plan coverage. |
| **Chemical Dependency** | A psychological and/or physical dependence on alcohol or a state-controlled substance. (Nicotine is not state-controlled and is not eligible under the chemical dependency benefit.) The pattern of use must be so frequent or intense that the user loses self-control over the amount and circumstances of use, develops symptoms of tolerance and, if use is reduced or discontinued, shows symptoms of physical and/or psychological withdrawal. The result is that health is substantially impaired or endangered or social or economic function is substantially disrupted. |
| **Coinsurance** | The amount you share with the plan toward covered expenses. |
| **Copay** | The fixed amount you pay at the time you receive the covered service. |
| **Custodial Care** | Care primarily to assist the patient in activities of daily living, including inpatient care mainly to support self-care and provide room and board. Examples are helping the patient to walk, get in and out of bed, bathe, dress, eat, prepare special diets or take medication that is normally self-administered. |

## DEFINITIONS (cont'd)

| | |
|---|---|
| **Dental Care** | Care of or related to the mouth, gums, teeth, mouth tissues, upper or lower jaw bones or attached muscle, upper or lower jaw augmentation or reduction procedures, orthodontic appliances, dentures and any care generally recognized as dental. This also includes related supplies, drugs and devices. |
| **Durable Medical Equipment** | Mechanical equipment that can stand repeated use and multiple users, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is prescribed by a provider. |

| | |
|---|---|
| **Emergency** | The sudden and unexpected onset of a condition, or exacerbation of an existing condition, requiring medically necessary care to safeguard your life or limb immediately after the onset of the emergency, as determined by Regence. To determine benefits, Regence will consider the symptoms of the condition and the actions that would have been taken by a prudent person under such circumstances. |
| **Emergency Service Patrol** | Personnel trained in first aid and how to respond to the addicted person, who patrol areas known to have a high concentration of alcohol and/or drug addicts and transport them to a hospital or treatment center if necessary. |
| **Formulary** | The plan's authorized list of generic and brand-name prescription drugs approved for use by the Food and Drug Administration. |
| **Generic Drugs** | Medications that are not trademark drugs, but are chemically equivalent to the brand-name drug. |
| **Hospice** | A private or public agency or organization with a hospice agency license that administers or provides a coordinated program of supportive care for a dying person. |
| **Hospital** | An institution licensed by the state and primarily engaged in diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured or ill persons by or under the supervision of a staff of physicians. The institution also continuously provides 24-hour nursing service by or under the supervision of registered nurses or in any other licensed institution where the plan has an agreement to provide hospital services.<br><br>The following are not hospitals: skilled nursing facilities, nursing homes, convalescent homes, custodial homes, health resorts, hospices or places for rest, the aged or to treat pulmonary tuberculosis. |
| **LEOFF I Employees** | Firefighters and law enforcement officers who are members of LEOFF Plan I. |
| **Lifetime Maximum** | The maximum benefit amount a plan participant may receive under the plan and prior Regence plans in his or her |

lifetime. This term is not intended to imply coverage is or will be available for anyone's full life.

**Manipulative Therapy** — Manipulation of the spine or extremities to correct a subluxation (incomplete or partial dislocation) shown by an x-ray.

**Medically Necessary** — A service or supply that meets all of the following criteria as determined by Regence:

- It is required to diagnose or treat the condition
- It is consistent with the symptoms or diagnosis and treatment of the condition
- It is the most appropriate supply or level of service that is essential to your needs
- When applied to an inpatient, it cannot safely be provided on an outpatient basis, including diagnostic studies
- It is not an investigational service or supply
- It is not primarily for the convenience of you or your provider.

The fact that a service or supply is furnished, prescribed, recommended or approved by a physician or other provider does not, of itself, make it medically necessary. A service or supply may be medically necessary in part only.

**Mental Condition** — A condition classified as such by the Diagnostic and Statistical Manual of Mental Conditions, fourth edition.

## DEFINITIONS (cont'd)

**Open Enrollment** — The annual period when eligible King County Deputy Sheriff employees may join a plan or change plans and add family member coverage.

**Participating Provider** — A provider whose name is included in the current list of participating providers for this plan as prepared by Regence and provided to the group, and who has signed a current participating agreement with Regence.

| | |
|---|---|
| **Participating Hospital** | A hospital whose name is included in the current list of participating hospitals for this plan as prepared by Regence and provided to the group, and who has signed a current participating agreement with Regence. |
| **Physician** | A licensed doctor of medicine (MD) or a licensed doctor of osteopathy (DO) who is an approved provider covered under this plan. |
| **Prescription Drug** | Any medical substance that, under the Federal Food, Drug and Cosmetic Act (as amended), must be labeled with "Caution: Federal Law prohibits dispensing without a prescription." |
| **Prosthesis** | An artificial substitute to replace a missing natural body part. |
| **Provider** | A person, group, organization or facility that provides medical services, equipment, supplies or drugs. This includes the following providers regulated under Title 18 of the RCW: naturopaths, acupuncturists and massage therapists. |
| **Referral** | An approved, prior authorization by an approved provider. |
| **Respite Care** | Time off or a break for someone who is the main caregiver for an aged, ill or disabled adult or child. |
| **Service Area** | The geographic area in Washington state where the plan is authorized by the Insurance Commissioner to arrange for covered services through agreements with plan providers. |
| **Skilled Nursing Facility** | A facility that provides room and board as well as skilled nursing care 24 hours a day and is accredited as an extended care facility or is Medicare-certified as a skilled nursing facility. It is not a hotel, motel or place for rest or domiciliary care for the aged. |
| **Temporomandibular Joint (TMJ) Disorders** | The temporomandibular joint connects the mandible or jawbone, to the temporal bone of the skull. TMJ disorders include those with 1 or more of the following characteristics:<br>• Pain in the musculature associated with the TMJ |

- Internal derangements of the TMJ
- Arthritic problems with the TMJ
- Abnormal range of motion or limited range of motion of the TMJ.

**Urgent Care**

A condition that is not life threatening but requires immediate medical attention.

**Women's Health Care Services**

These include the following health care services:

- Maternity care
- Reproductive health services
- Gynecological care
- General examinations and preventive care as medically appropriate
- Medically appropriate follow-up visits for the above services.

## PARTICIPANT BILL OF RIGHTS

*If you have questions about your benefits contact your plan as shown in the Directory.*

As a plan participant, you have certain rights, as described below.

### Dignity and Respect

You have the right to be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients.

You have the right to see your own medical records and to have those records kept private and confidential unless required to settle a claim.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

## Knowledge and Information

*You also have the right to take an active part in decisions about your care. Once you participate in and agree to a treatment plan, you are responsible for following that plan or telling your physician otherwise.*

You have the right — and the responsibility — to know about and understand your health care and your coverage, including:

- Names and titles of all providers involved in your care
- Medical condition and health status
- Services and procedures involved in your treatment plan
- Ongoing health care you need once you're discharged or leave the physician's office
- How the plan works (you will find that information in this booklet)
- Medication prescribed for you — what it is, what it's for, how to take it properly and possible side effects.

## Continuous Improvement

*You are partners with your plan, your physician and other health care providers involved in your care.*

You have the right to:

- Call or write with any questions or concerns and make suggestions for improving the plan
- Ask your provider to explain or give you more information about any medical advice or prescribed treatment
- Appeal any medical or administrative decisions (see "Appealing a Claim" on page 41).

## Plan Participant Accountability and Autonomy

As a partner in your own health care, you have the right to:

- Refuse treatment — as long as you accept responsibility and the consequences of that decision
- Complete an advance directive, such as a living will or durable power of attorney, for health care
- Refuse to take part in any medical research projects

- Be advised of the full range of treatment options (whether covered under this plan or not) and their potential risks, benefits and costs
- Make the final choice among treatment alternatives.

You also are responsible to:

- Show your identification card to your physician, hospital or other provider before you receive care
- Provide your current doctor with all previous medical records and give accurate, complete medical information to all physicians or other providers involved in your care
- Be on time for appointments and let your provider's office know as far in advance as you can if you need to cancel or reschedule
- Follow instructions given by those providing your care

*If you decide to give someone else the legal power to make decisions about your health care, that person will also have all of these rights and responsibilities.*

## Plan Participant Accountability and Autonomy (cont'd)

- Send copies of claim statements or other documents if requested
- Let your plan know within 24 hours or as soon as reasonably possible if you receive emergency care or out-of-area urgent care
- Tell your plan and your provider about planned health care, such as a surgery or an inpatient stay
- Pay all required copays when you receive health care.